STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155768	A. BUILDING 00 B. WING	02/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSVILLE PROTESTANT HOME INC	3701 WASHINGTON AVE EVANSVILLE, IN 47714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure survey. Survey Dates: February 8, 9, 10, 13, 14, 15, 2012 Facility Number: 001125 Provider Number: 155768 AIM Number: N/A Survey Team: Diane Hancock, RN, TC Vickie Ellis, RN Barbara Fowler, RN Amy Wininger, RN Census Bed Type: SNF= 39 NCC [Non Certified Comprehensive]=17 Residential=69 Total= 125 Census Payor Type: Medicare=13 Other= 112 Total=125 Sample: 10 NCC Sample: 2 Supplemental Sample NCC: 5 Residential Sample: 7	F0000	Please accept this plan of correction as or credible allegation of compliance, this plan of correction is submitted as part of regulatory required response and should not be construed as agreement with the deficiencies cited.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 2/16/12 Cathy Emswiller RN			

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	Based on observation, interview and record review, the facility failed to ensure the care plan was followed for assisting the resident with eating, for 1 of 3 residents observed for needing assistance with eating, in the sample of 10. (Resident #19) Finding includes: Resident #19's clinical record was reviewed on 2/9/12 at 10:32 a.m. The resident's diagnoses included, but were not limited to, the following: depression, failure to thrive, atrial fibrillation, dementia, hypertension, and osteoporosis. Resident #19's most recent quarterly Minimum Data Set [MDS] assessment, dated 11/14/11, indicated the resident required limited assistance of one person for eating. The resident had a care plan, dated 1/20/11 with an ongoing target date of 2/19/12, for requiring extensive assistance with activities of daily living, including eating. Interventions included, but were not limited to, the following: "-Assess residents mental status q [every] a.m. to evaluate need for assistance... -Encourage consumption of meals and record consumption..."	F0282	**F-282 Persons/Personal Care Plan What corrective action will be accomplished for the resident found to be affected by the deficient practice?** Resident #19 has been moved to an assist table for more direct interaction with staff. Resident #19 had weight loss from Jan week 4 of weights to February week 1 of weights due to a gastrointestinal virus. Resident #19 weight had been identified the week before survey and she was already receiving health shakes as a supplement for her weight loss and Remeron as an appetite stimulant. Family and physician are aware of decrease in weight. As of 2-28-12, the resident no longer resides at the facility.**How other residents potentially affected will be identified and corrective actions taken?** All residents have the potential to be affected. Under the direction of the DON, care plans shall be audited for assist with eating. All residents identified to have an assist with eating care plan have had their food consumption record reviewed to ensure proper intake. **What measures shall be put in place or systemic changes made to ensure the deficient practice does not recur?** To enhance currently	03/15/2012

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	The resident had a care plan, dated 8/19/11, with an ongoing target date of 2/19/12, for a history of failure to thrive. The interventions included, but were not limited to, the following: "-Stay with her during mealtime and encourage to eat 100% of meals served... -Evaluate for restorative dining program.. -Monitor and record weights... -Offer substitute for uneaten meal... -staff assist with meals prn [as needed]" The resident's most recent Nutrition Risk Assessment, dated 1/31/12, indicated the following: "Resident [with] unintended wt. [weight] loss over past 90 and 180 days and low BMI [basal metabolic index]." "Resident is seen monthly in NRT [nutritional risk team] meetings. She has had wt. loss past 6 months. She receives 2-cal, health shakes and receives Remeron [medication used for appetite stimulant] to [increase] appetite. 2 cal was [increased] to 120 cc [cubic centimeters] TID [three times a day] last week..." Review of the Meal Consumption Record for February, 2012, included, but was not limited to, the following: 2/9/12 breakfast, 25 percent 2/9/12 lunch, 0 [zero] 2/9/12 supper, 0 [zero]		complaint operations, under the direction of the DON, nursing staff shall receive in servicing regarding care plan interventions which shall include but is not limited to assisting with eating. The DON or designee shall make rounds in the dining rooms to ensure residents identified to need assist with eating are receiving assistance. **How corrective actions will be monitored to ensure the deficient practice will not recur?** Effective 3-12-12, a Quality Assurance program was implemented to ensure continued monitoring of identified residents who need assist with eating is implemented. All audits will be completed daily for 4 weeks, 5 times a week for 3 weeks, and 3 times a week for 3 weeks and then weekly thereafter. Any variation in regulatory guidelines will be corrected immediately. All audits will be submitted to the Quality Assurance Committee for review and/or further corrective action. Audits will not titrate down unless the QA committee deems 100% compliance was achieved.	

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	2/10/12 breakfast, 25 percent 2/10/12 lunch, 25 percent 2/10/12 supper, R [refused] 2/11/12 breakfast, R [refused] 2/11/12 lunch, 25 percent 2/11/12 supper, R [refused] 2/12/12 breakfast, R [refused] 2/12/12 lunch, 0 [zero] 2/12/12 supper, 0 [zero] 2/13/12 breakfast, R [refused] 2/13/12 lunch, R [refused] 2/13/12 supper, 0 [zero] The resident's recorded weights included the following: January week 1 99.6, week 2 100, week 3 98.4, week 4 97, February week 1 91.4, week 2 94. The resident was treated for a urinary tract infection from 2/6 through 2/13/12. On 2/13/12 at 5:00 p.m., Resident #19 was observed during the evening meal. She sat at the table with three other residents. She made no effort to feed herself. No one was observed to attempt to assist the resident to eat. On 2/14/12 at 12:00 noon, LPN #1 was observed to deliver Resident #19's meal tray to her. Her meat was cut up, drinks opened, supplement poured into a cup, and silverware set up. The resident was observed to sit in her wheelchair, with her head in her hand and make no effort to			

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	feed herself until 12:35 p.m. No staff members were observed to interact with the resident during that time. At that time, her table mate was observed talking to her and encouraging her to eat. The resident was observed to pick up a fork at that time and feed herself two bites of food. She was observed to take a couple sips of lemonade. The observations were reviewed with the Administrator and Director of Nursing on 2/14/12 at 3:20 p.m. During interview at that time, they indicated they weren't sure the resident would allow anyone to feed her, but indicated someone should have attempted, or at least encouraged the resident to eat. 3.1-35(g)(2)			

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F0312 SS=D	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review, the facility failed to ensure 1 of 3 residents observed for needing assistance with eating, in the sample of 10, was provided assistance. (Resident #19) Finding includes: Resident #19's clinical record was reviewed on 2/9/12 at 10:32 a.m. The resident's diagnoses included, but were not limited to, the following: depression, failure to thrive, atrial fibrillation, dementia, hypertension, and osteoporosis. Resident #19's most recent quarterly Minimum Data Set [MDS] assessment, dated 11/14/11, indicated the resident required limited assistance of one person for eating. The resident had a care plan, dated 1/20/11 with an ongoing target date of 2/19/12, for requiring extensive assistance with activities of daily living, including eating. Interventions included, but were not limited to, the following: "-Assess residents mental status q [every] a.m. to evaluate need for assistance... -Encourage consumption of meals and record consumption..."	F0312	**F-312 ADL Care Provided for Dependent Residents What corrective action will be accomplished for the resident found to be affected by the deficient practice?** Resident #19 has been moved to an assist table for more direct interaction with staff. Resident #19 had weight loss from Jan week 4 of weights to February week 1 of weights due to a gastrointestinal virus. Resident #19 weight had been identified the week before survey and she was already receiving health shakes as a supplement for her weight loss and Remeron as an appetite stimulant. Family and physician were also already aware of decrease in weight. **How other residents potentially affected will be identified and corrective actions taken?** All residents have the potential to be affected. Under the direction of the DON, care plans shall be audited for assist with eating. All residents identified to have an assist with eating care plan have had their food consumption record reviewed to ensure proper intake. **What measures shall be put in place or systemic changes made to ensure the deficient practice does not recur?** To enhance currently	03/15/2012

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	The resident had a care plan, dated 8/19/11, with an ongoing target date of 2/19/12, for a history of failure to thrive. The interventions included, but were not limited to, the following: "-Stay with her during mealtime and encourage to eat 100% of meals served... -Evaluate for restorative dining program.. -Monitor and record weights... -Offer substitute for uneaten meal... -staff assist with meals prn [as needed]" The resident's most recent Nutrition Risk Assessment, dated 1/31/12, indicated the following: "Resident [with] unintended wt. [weight] loss over past 90 and 180 days and low BMI [basal metabolic index]." "Resident is seen monthly in NRT [nutritional risk team] meetings. She has had wt. loss past 6 months. She receives 2-cal, health shakes and receives Remeron [medication used for appetite stimulant] to [increase] appetite. 2 cal was [increased] to 120 cc [cubic centimeters] TID [three times a day] last week..." Review of the Meal Consumption Record for February, 2012, included, but was not limited to, the following: 2/9/12 breakfast, 25 percent 2/9/12 lunch, 0 [zero] 2/9/12 supper, 0 [zero]		complaint operations, under the direction of the DON, nursing staff shall receive in servicing regarding care plan interventions which shall include but is not limited to assisting with eating. The DON or designee shall make rounds in the dining rooms to ensure residents identified to need assist with eating are receiving assistance. **How corrective actions will be monitored to ensure the deficient practice will not recur?** Effective 3-12-12, a Quality Assurance program was implemented to ensure continued monitoring of identified residents who need assist with eating is implemented. All audits will be completed daily for 4 weeks, 5 times a week for 3 weeks, and 3 times a week for 3 weeks and then weekly thereafter. Any variation in regulatory guidelines will be corrected immediately. All audits will be submitted to the Quality Assurance Committee for review and/or further corrective action. Audits will not titrate down unless the QA committee deems 100% compliance was achieved.	

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	2/10/12 breakfast, 25 percent 2/10/12 lunch, 25 percent 2/10/12 supper, R [refused] 2/11/12 breakfast, R [refused] 2/11/12 lunch, 25 percent 2/11/12 supper, R [refused] 2/12/12 breakfast, R [refused] 2/12/12 lunch, 0 [zero] 2/12/12 supper, 0 [zero] 2/13/12 breakfast, R [refused] 2/13/12 lunch, R [refused] 2/13/12 supper, 0 [zero] The resident's recorded weights included the following: January week 1 99.6, week 2 100, week 3 98.4, week 4 97, February week 1 91.4, week 2 94. The resident was treated for a urinary tract infection from 2/6 through 2/13/12. On 2/13/12 at 5:00 p.m., Resident #19 was observed during the evening meal. She sat at the table with three other residents. She made no effort to feed herself. No one was observed to attempt to assist the resident to eat. On 2/14/12 at 12:00 noon, LPN #1 was observed to deliver Resident #19's meal tray to her. Her meat was cut up, drinks opened, supplement poured into a cup, and silverware set up. The resident was observed to sit in her wheelchair, with her head in her hand and make no effort to			

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	feed herself until 12:35 p.m. No staff members were observed to interact with the resident during that time. At that time, her table mate was observed talking to her and encouraging her to eat. The resident was observed to pick up a fork at that time and feed herself two bites of food. She was observed to take a couple sips of lemonade. The observations were reviewed with the Administrator and Director of Nursing on 2/14/12 at 3:20 p.m. During interview at that time, they indicated they weren't sure the resident would allow anyone to feed her, but indicated someone should have attempted, or at least encouraged the resident to eat. 3.1-38(a)(2)(D)			

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F0368 SS=D	Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.			
	Based on observation, interview, and record review, the facility failed to ensure a resident on the North Nursing Unit was offered a bedtime snack, in that 1 of 3 sampled alert and oriented residents interviewed, in the sample of 10, indicated bedtime snacks were not offered. (Resident #60) Finding includes: During the group meeting on 02/09/12 at 11:00 A.M., the one (1) resident in attendance (Resident 60) was identified at that time, by the Activity Director to be interviewable. During interview at that time, the resident indicated bedtime snacks were not offered.	F0368	**F-368 Frequency of meals/snacks at Bedtime What corrective action will be accomplished for the resident found to be affected by the deficient practice?** Resident #60 was a resident council interview with surveyors. The facility is unable to identify resident #60. **How other residents potentially affected will be identified and corrective actions taken?** All residents have the potential to be affected. Under the direction of the DON, food consumption records shall be audited for bedtime snack documentation. There are no residents who had an incomplete bedtime snack record and a weight loss.**What measures shall be put in place or systemic changes made to**	03/15/2012

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	The food consumption records of the resident were reviewed on 02/14/12 at 10:35 A.M. The consumption record did not include any documentation an evening snack had been offered or consumed. During an interview with CNA #1 on 02/14/12 at 10:30 A.M. she indicated each resident was offered juice from the hydration cart, and she had their preferences memorized. She further indicated she did not offer a food snack but, if they asked for a snack, she would get it for them. During an interview with the DoN [Director of Nursing] on 02/14/12 at 3:15 P.M., she indicated there was no documentation food snacks were offered in the evening. 3.1-21(e)		**ensure the deficient practice does not recur?** To enhance currently complaint operations, under the direction of the DON, nursing staff shall receive in servicing regarding bedtime snack documentation, bedtime snack location, and timing of snack offering. All residents shall have the 2 nd shift nurse review the food consumption record for complete documentation of snacks offered. Fluids offered shall be documented in cc and food in %. Refusals shall be marked with an R. Any variation shall result in immediate communication to the nursing staff for correction.**How corrective actions will be monitored to ensure the deficient practice will not recur?** Effective 3-12-12, a Quality Assurance program was implemented to ensure continued monitoring of the bed time snack is completed. The DON or designee will audit the bedtime snack record daily. All audits will be completed daily for 4 weeks, 5 times a week for 3 weeks, and 3 times a week for 3 weeks and then weekly thereafter. Any variation in regulatory guidelines will be corrected immediately. All audits will be submitted to the Quality Assurance Committee for review and/or further corrective action. Audits will not titrate down unless the QA committee deems 100% compliance was achieved.	

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F9999	STATE FINDINGS (e) The facility must offer snacks at bedtime daily. This State Rule was not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents on the North Nursing Unit were offered a bedtime snack in that, 5 of 5 supplemental sample alert and oriented residents indicated they were not offered bedtime snacks, in a supplemental sample of 5. (Residents #57, #58, #59, #61, #62) Finding includes: During the group meeting on 02/09/12 at 11:00 A.M., the five (5) residents in attendance (Residents 57, 58, 59, 61, 62) were identified at that time, by the Activity Director to be interviewable. During the interview at that time, all five residents indicated they were not offered a bedtime snack. The food consumption records of the residents were reviewed on 02/14/12 at 10:35 A.M.. The consumption records	F9999	**F-9999 What corrective action will be accomplished for the resident found to be affected by the deficient practice?** Resident #57, 58, 59, 61 and #62 were resident council interview with surveyors. The facility is unable to identify resident #57, 58, 59, 61 and #62.**How other residents potentially affected will be identified and corrective actions taken?** All residents have the potential to be affected. Under the direction of the DON all food consumption records shall be audited for bedtime snack documentation. There are no residents who had an incomplete bedtime snack record and a weight loss. **What measures shall be put in place or systemic changes made to ensure the deficient practice does not recur?** To enhance currently complaint operations, under the direction of the DON, nursing staff shall receive in servicing regarding bedtime snack documentation, bedtime snack location, and timing of snack offering. All residents shall have the 2 nd shift nurse review the food consumption record for complete documentation of snacks offered. Fluids offered shall be documented in cc and food in %. Refusals shall be marked with an R. Any variation shall result in immediate communication to the nursing	03/15/2012

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	did not include any documentation an evening snack had been offered or consumed. During an interview with CNA #1 on 02/14/12 at 10:30 A.M., she indicated each resident was offered juice from the hydration cart, and she had their preferences memorized. She further indicated she did not offer a food snack but, if they asked for a snack, she would get it for them. During an interview with the DoN [Director of Nursing] on 02/14/12 at 3:15 P.M., she indicated there was no documentation food snacks were offered in the evening. 3.1-21(e)		staff for correction. **How corrective actions will be monitored to ensure the deficient practice will not recur?** Effective 3-12-12, a Quality Assurance program was implemented to ensure continued monitoring of the bedtime snack documentation is completed. The DON or designee will audit the bedtime snack record daily. All audits will be completed daily for 4 weeks, 5 times a week for 3 weeks, and 3 times a week for 3 weeks and then weekly thereafter. Any variation in regulatory guidelines will be corrected immediately. All audits will be submitted to the Quality Assurance Committee for review and/or further corrective action. Audits will not titrate down unless the QA committee deems 100% compliance was achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155768	A. BUILDING 00 B. WING	02/15/2012

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R0000				
	The following Residential Findings were cited in accordance with 410 IAC 16.2-5. Quality review completed 2/16/12 Cathy Emswiller RN	R0000	Please accept this plan of correction as or credible allegation of compliance, this plan of correction is submitted as part of regulatory required response and should not be construed as agreement with the deficiencies cited.	

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R0273	(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure food was served under sanitary conditions, in that a window was opened to the outside with a ripped screen in place, a ceiling tile was out of place exposing insulation, the ventilation hood over the food preparation area had peeling paint, the top of the water pipes above the steam table were dirty, and the dishwashing area had mold on the backslash, for 1 of 1 observation of the North kitchen. This had the potential to affect 33 of 33 residents who resided in the North residential units and have meals served from the North kitchen. Findings include: During the observation of the North kitchen of 02/13/12 at 1:00 P.M., the following was observed: a. An outside window was noted to be open with a torn screen in place. During an interview at that time, the CDM [Certified Dietary Manager] indicated the screen needed to be replaced. b. The ceiling tile over the steam table was observed to be pushed to the side exposing the insulation. During an	R0273	**R-273 Food and Nutritional Services What corrective action will be accomplished for the resident found to be affected by the deficient practice?** Residents served from the North kitchen have suffered no ill effects.**How other residents potentially affected will be identified and corrective actions taken?** All residents have the potential to be affected. Residents have suffered no ill effects.**What measures shall be put in place or systemic changes made to ensure the deficient practice does not recur?** The north and the south kitchen shall have sanitation inspection completed by the CDM or designee to ensure sanitation concerns have been identified. Work orders shall be completed for issues not identified in the survey. Work order in-servicing shall be completed for dietary department to ensure staff education of the work order process and the importance of communication to the environmental services department. The safety committee shall meet monthly to review sanitation inspections performed by the registered dietician or designee and work order completion of identified	03/15/2012

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	interview at that time, the CDM indicated she did not know why the ceiling was open, but it shouldn't be. c. The ventilation hood over the food prep area was observed to have multiple areas of peeling paint. During an interview at that time, the CDM indicated the peeling paint needed to be taken care of. d. The top of the water pipe over the steam table was observed to be coated with a dark dust-like substance. During an interview at that time, the CDM indicated the substance appeared to be dirt and dust and needed to be cleaned. e. The backslash of the dishwashing area was observed to be discolored with a black mold-like substance at the caulk line. During an interview at that time, the CDM indicated the black substance appeared to be mold.		issues for proper communication. **How corrective actions will be monitored to ensure the deficient practice will not recur?** Effective 3-12-12, a Quality Assurance program was implemented to ensure continued monitoring of the work order process and sanitation report completion. The CDM or designee will audit both the north and south kitchen 5 times a week for 3 weeks, and 3 times a week for 3 weeks and then weekly thereafter. Any variation in regulatory guidelines will be corrected immediately. All audits will be submitted to the Quality Assurance Committee for review and/or further corrective action. Audits will not titrate down unless the QA committee deems 100% compliance was achieved.	